

CURRENT STANDARD OPERATING PROCEDURES INCLUDE THE FOLLOWING SCENARIO

1. Lincoln Fire & Rescue is called to respond to either an emergency or non-emergency with an attending the Lincoln Fire & Rescue paramedic who completes a "run report" containing information found at the scene and procedures performed to treat and/or transport the patient.
 - 1.1 Lincoln Fire & Rescue staffs all ALS ambulances.
2. The Lincoln Fire & Rescue paramedic completes a run report on the City's computer system.
3. Run reports are electronically sent on a daily basis (Monday through Friday) to the billing company.
 - 3.1 Signature forms, PCS's, Face Sheets and other paperwork received by LFR are scanned and images are made available to the billing company to view these images on-line.
 - 3.2 Upon receipt of information from the Lincoln Fire & Rescue (which may include data gathered by Lincoln Fire personnel and hospital personnel), proposer shall review the charge record to determine:
 - 3.2.1 Whether the information provided is sufficient to bill a financially responsible party.
 - 3.2.2 If the charge record is not sufficient, proposer shall notify Lincoln Fire & Rescue that the data is incomplete and specify what is lacking.
 - 3.2.3 If the charge record is sufficient, proposer shall code (HCPCS; IC-D9, etc.) the call and bill appropriate financially responsible parties.
4. The proposer submits claim forms to appropriate insurance carrier or invoices client directly as needed;
5. The insurance agency or individual remits payment (payable to the CITY OF LINCOLN, NEBRASKA *only*) to the lock box;
 - 5.1 The bank then copies the check and all paperwork sent with the check and sends it to the billing agency;
 - 5.2 The billing agency records the payment or adjustment information on the patients account.
6. Partial payments require that claims be re-submitted, billed to another carrier or to the patient directly as allowed (the proposer shall "BALANCE BILL" all sums over \$10.00.)
7. Daily the proposer submits a report of all individual client accounts showing the run number (which is required and which will be the control), the client's name and associated data, the agency where the payment originated:
 - 7.1 The current process is:
 - 7.1.1 Lock box receives money
 - 7.1.2 City Finance reports to LFR the monies received
 - 7.1.3 Billing company sends a daily report to LFR that outlines deposit total, split between emergency and non-emergency revenue
 - 7.1.4 LFR reconciles the amount the billing company has given them to the amount City Finance has reported.
 - 7.1.5 The deposit is then recorded into the City's finance system after reconciling the split.
8. Billing company shall submit a monthly statement showing the below information before payment can be made:
 - 8.1 Amount collected for emergency
 - 8.2 Credits and refunds done for emergency
 - 8.3 Amount collected for non-emergency
 - 8.4 Credits and refunds for non-emergency
9. At the present time the City does not bill for Extractions or Hazmat services, however should the city change it's policies and decide to bill, it is understood it will be included in this contract.

Rates Charged

ATTACHMENT B

	Jan 1, 2001 to Aug 31, 2002	Sept 1, 2002 to Aug 31, 2003
ALS Treat & Release	\$ 250.00	\$ 250.00
Paramedic Intercept	\$ 275.00	\$ 275.00
BLS Non-Emergency	\$ 300.00	\$ 310.00
BLS Emergency	\$ 400.00	\$ 415.00
ALS Non-Emergency	\$ 495.00	\$ 495.00
ALS 1 Emergency	\$ 495.00	\$ 513.00
ALS 2 Emergency	\$ 495.00	\$ 550.00
Specialty Care Transport	\$ 495.00	\$ 550.00
Mileage	\$ 8.00	\$ 8.25
Team Transport	\$ 75.00	\$ 75.00
ALS Ambulance Standby	\$72 per hour	\$72 per hour
ALS Event Team Standby	\$55 per hour	\$55 per hour

Reports

All Reports are to be given listing details for Emergency Revenue Division, Non-Emergency Revenue Division and a Total for both divisions. Capability of the reports shall be such that they are able to include additional added Revenue Divisions should the City decide to add at a later date.

Reports shall be customizable upon the City's request and access shall be given to the City to query our data for any captured data.

Daily Reports: To be delivered electronically on a daily basis.

1. Detailed list of payments. List is to include but not limited to: Billing company account number, Billing company batch, Incident number, City's revenue center, Patient name, Date of payment, Amount of payment, and Type of payment. The payments recorded must match the total dollar amount deposited into the city's lock box account. The total dollar figure shall be listed on the report showing a split of the total for Emergency and a total for Non-Emergency. This report will also need to show a detailed report showing any payments received by the billing company for any account that has been sent to the collection agency.
2. A financial summary showing, Today, Month to Date, and Year to Date (based on the city's fiscal year) numbers. This report is to include but not limited to: Date, Total Charges, Total Payments, (including a breakdown of most popular types of payments), Total Adjustments (including insurance adjustments, refunds, bad debt write off's, etc.),
3. Accounts Receivable Summary Report showing age of accounts and responsible party.

Twice Per Month: Once on the first of each month that includes all transactions posted through the last day of the previous month, the second, on the 16th of each month that will include all transactions posted through the 15th of the month. These reports are to be delivered electronically no later than the 2nd and the 17th of each month.

1. Details on a Financial summary to include all transactions relating to the Month of service. Details of this report shall include but not limited to Total Charges, Total adjustments made detailing out dollar amount for each type of adjustment (examples: Insurance Adjustments, collection adjustments, estates, small balance, etc.), Payments made for transports done during this Month of service, Refunds done, Amount of payments less refunds, Net remaining split out by amount remaining in patient balance and amount in insurance balance. Report is to be

maintained 3 months after the Month of service has a zero dollar balance in net remaining.

2. Report on call volume relating to the month of service. Report shall detail out the number of calls for each type of bill sent for the month of service the call was done. (Example: BLS transport, ALS transport, Mileage, Standby's, Specialty care transports, Intercepts, ALS treat & release, non-billable items, etc..) A total at the end of the report shall include a total to show the number of transports billed in a given month. Report is to be maintained 3 months after the Month of service has a zero dollar balance in net remaining.

Monthly: Report will show all activity from the 1st of the month through last day of the month and shall be delivered to the City by the 10th of the following month.

1. Detailed Accounts Receivable report listing all patient's with open balances. Report will include but not limited to date of service, age of account, beginning balance, payments, adjustments made, remaining balance and if balance is in insurance or patient responsibility.
2. Financial summary showing Accounts Receivable information to include totals for the Month and for Year-to-Date (based on past 12 months of history). This report will be by activity done in a given month. Details will show Total Charges, Contractual Obligations Applied to Accounts, Refunds done, Other Adjustments (includes any type of adjustment made on accounts other than refunds and contractual obligations) Payments received, Ending Accounts Receivable balance. Report shall also show collection percentages for Gross and Net, as well as Average days of Accounts Receivable.

QUESTIONNAIRE

1. State cost for any additional services not listed in RFP:
Hourly -
Daily -
Other -
2. Please state and detail any charges for start-up, installation and conversion of existing accounts receivable and all new business commencing June 1, 2003.
2.1 please split out costs for existing accounts and for new business.
3. Please state and detail any additional fees/charges:
4. State the amount of time required for completion of the proposed services and provide a time line:
Total time required to get up and going.
Should the time frame be excessive the City may want to submit un reports by paper verses electronically so as not to interrupt cash flow.
Comments:
5. Should your company be awarded the contract, please list what assistance you would immediately require from the City so that we may eliminate an interrupted cash flow.

TECHNICAL INFORMATION

1. Please indicate project manager/primary consultant for emergency billing services and accounts receivable activities.
2. List credentials of project manager for emergency billing services and accounts receivable activities.
3. List EMS billing and accounts receivable experience(s) of project manager for EMS billing services.
4. List the individuals in the office that are certified coders by one of the two national coding organizations for billing services.
 - 4.1 Include with the proposal copies of said certifications
 - 4.2 Identify which certified coders would be assigned to our account and what responsibilities they would have as it relates to this RFP.
5. Describe any characteristics or capabilities which may make the proposer uniquely qualified to provide the EMS medical billing service and accounts receivable activities.
- 6a. Identify at least five (5) clients who have direct knowledge of the proposer's billing service and accounts receivable activities. Information shall include:
 - Entity:
 - Address:
 - Contact person: Phone:
 - Type of Medical Billing Service:
 - Date of Services:
 - Briefly Describe Scope of Service:
 - How many bills generated during last six months:

- 6b. Provide all customers who have terminated within the past two years. Information shall include:
- Entity:
 - Address:
 - Contact person: Phone:
 - Type of Medical Billing Service:
 - Date of Services:
 - Reason for terminating:
7. Please provide a description of the firm, its organization, size and nature of general services, office facilities available, and a description of any special equipment which will assist in fulfilling the services solicited herein. Specify the software supplier used and its version.
8. Describe the hardware to be used, the safeguards and protections and the backup process.
- 8.1 Include a discussion of HIPAA compliance including the security, privacy and transaction codes.
9. Describe the generation of patient statements, who, when, why and what, does the patient receive.
10. Discuss in detail how the City would recover from a default by the successful proposer during the contractual period using the medical accounts receivable software. Explain how we would recover if you or your software vendor should stop doing business.
11. Discuss the document imaging system to be used and how it will benefit the Lincoln Fire & Rescue needs described herein:
12. Discuss the on-site training to be provided to City staff:
- 12.1 How often and what type of training will be provided at no cost to the City?
 - 12.2 How often are refresher courses given?
13. Discuss the system to be used for Lincoln Fire & Rescue and how it will be made available to monitor billing activities and accounts receivables:
- 13.1 Is it an on-line real-time system?
14. Describe the composition of your firm's commitments, the volume and size, number of transactions, then list the percentage of total volume of each.
15. List the capabilities of your firm to receive data (demographics and run report information) from the Lincoln Fire & Rescue electronically.
16. List the capabilities of your firm to send and receive data (demographics, charges and payment information) to and from insurance companies for payment electronically.
17. Describe your billing/claim follow-up process.
18. Submit samples of your standard reports, including patient data reports or screen prints. Include any reports which show the effectiveness of your firm. How is your ad hoc reporting data base language capabilities accessed, Microsoft, D-base 4 SQL, etc.
19. Provide evidence of success in the billing and collection of fees processed to sustain a gross percentage of collections suitable for a successful operation.
- 19.1 Show how and what items are used in the calculation.
 - 19.2 How will your company maximize revenues for the City of Lincoln? Explain in detail.
20. Please explain the process used when receiving notices of estates and bankruptcies.
- 20.1 What is your firms success of collecting on bankruptcies and estates?
21. On all EMS accounts, what percentage of claims are written off for "out of timely filing"?
- 21.1 What situations occur to cause out of timely filing?

22. Does your firm have experience in billing for Extractions and Hazmat services?
23. What are your firms average days of accounts for all EMS Accounts.
 - 23.1 Please clarify how these figures are arrived at.
24. How has your firm prepared for HIPAA? Be specific on security, privacy and transaction codes.
25. Any additional information necessary to assist the City in evaluating your proposal may be listed here.
26. Attached are some sample run reports (Attachment J). Please submit a HCFA 1500 claim form for them.
 - 26.1 Please explain what additional forms or information would be required prior to filing the claim to Medicare.
27. List all names your company has operated under.
 - 27.1 Has your company now or ever been under investigation or sued for fraud at any time?
 - 27.2 Are you now or have you ever been subject to a corporate integrity agreement under a Federal Healthcare Program?
28. Briefly explain when an Advance Notice of Beneficiary is needed.
29. Please include your comments on having Billing/Collecting and Bad Debt Collection being performed by the same company.
 - 29.1 Describe your company's process in dealing with payments received after account has been turned over to collections.
 - 29.2 Explain processed used if insurance is needed to be filed after the account is at Collections.
 - 29.3 Explain your process when accounts are turned over to bad debt collections:
 - 29.3.1 Time line
 - 29.3.2 Information given on account
 - 29.3.3 History on percent of accounts turned to collections.
30. Specify any additional data you will need provided by the City not presently collected by LFR per attachments, in order to bill a financially responsible party, including specifically Medicare and Nebraska Medicaid.
31. Explain the process taken when a patient calls to say they are unable to pay their balance.
32. What abilities do you have to recreate a call from 1st response and how do you do it?
33. Does your firm provide "Statement on Auditing Standard" (SAS) Number 70 Audit Report?

LFD Data to Billing Company Layout

FIELD NAME	LENGTH	DATA TYPE
WA-H-INC-NO	10	Numeric
WA-H-EXP-NO	2	Numeric
WA-H-EMS	7	Numeric
WA-H-UNIT-ID	4	
WA-H-PAT-NO	2	Numeric
WA-H-PAT-NAME	30	
WA-H-PAT-ADDR	30	
WA-H-PAT-CITY-ST	30	
WA-H-PAT-ZIP	5	Numeric
WA-H-PAT-DOB	10	
WA-H-PAT-SSN	9	Numeric
WA-H-PAT-SEX	1	
WA-H-INC-LOCATION	35	
WA-H-ALARM-TS	26	
WA-H-DISPATCH-TS	26	
WA-H-LOC-ENROUTE-TS	26	
WA-H-LOC-ARRIVED-TS	26	
WA-H-HOSP-ENROUTE-TS	26	
WA-H-HOSP-ARRIVE-TS	26	
WA-H-INSERVICE-TS	26	
WA-H-ACT-TKN	15	
WA-H-SIT-FND	15	
WA-H-METH-OF-ALARM	15	
WA-H-LOC-PROP-TYPE	30	
WA-H-AMB-DISP-FLAG	1	Numeric
WA-H-CALL-LEVEL	10	
WA-H-CASUALTY-TYPE	10	
WA-H-DISPATCHED-AS	25	
WA-H-RESPONSE-LEVEL	25	
WA-H-CHIEF-COMPLAINT	25	
WA-H-SERV-REFUSED	25	
WA-H-SEVERITY-LEVEL	15	
WA-H-PUPILS	15	
WA-H-CHEST	25	
WA-H-SKIN-MOIST	25	
WA-H-SKIN-COLOR	25	
WA-H-ABDOMEN	25	
WA-H-TEMP	4	Decimal 3.1
WA-H-APGAR-SCORE	3	Numeric
WA-H-BURN-SCORE	3	Numeric
WA-H-PULSE-OXIMETER	3	Numeric
WA-H-CONTROL-HOSP	25	
WA-H-RECEIVE-FACILITY	25	
WA-H-MODE-OF-TRANS	15	
WA-H-VEHICLE-INFO	15	

LFD Data to Billing Company Layout

WA-H-PARAMEDIC	4	
WA-H-MED-COUNT	2	Numeric
WA-H-ALL-CNT	2	Numeric
WA-H-CUR-CNT	2	Numeric
WA-H-IMP-CNT	2	Numeric
WA-H-VIT-CNT	2	Numeric
WA-H-TRE-CNT	2	Numeric
WA-H-ACT-CNT	2	Numeric
WA-H-CMT-CNT	2	Numeric
WA-H-NAR-CNT	2	Numeric
WA-H-MED-HISTORY	4times	
Data	20	
WA-H-ALLERGIES	4times	
Data	20	
WA-H-CUR-MEDS	10times	
Data	20	
WA-H-IMPRESSION-ROW	20times	
WA-H-IMPRESSIONS	25.	
WA-H-MAJOR-BODY-PART	15.	
WA-H-MINOR-BODY-PART	15.	
WA-H-VITAL-ROW	20times	
WA-H-VIT-TIME	8.	
WA-H-VIT-POSITION	15.	
WA-H-VIT-RESP	3.	Numeric
WA-H-VIT-BLDPRES	6.	
WA-H-VIT-PULSE	3.	Numeric
WA-H-VIT-LOC	15.	
WA-H-VIT-RHYTHM	15.	
WA-H-TREATMENTS	10times	
WA-H-TREATMENT	25	
WA-H-ACT-PERF-MEDS-GIVEN	20times	
WA-H-GIV-TIME	8.	
WA-H-GIV-EMPID	4.	
WA-H-GIV-ACTION	30.	
WA-H-GIV-ATTEMPT	1.	
WA-H-GIV-SUCCESS	1.	
WA-H-GIV-AMOUNT	6.	
WA-H-GIV-SIZE	4.	Decimal 3.1
WA-H-GIV-LOCATION	15.	
WA-H-GIV-EFFECT	15.	
WA-H-GIV-BASE	1.	
WA-H-MEDICAL-COMMENTS	50times	
WA-H-COMMENTS	65	
WA-H-INC-NARRATIVE	25 Times	
WA-H-NAR-UNIT	4	
WA-H-NAR-COM	70	
WA-H-HOSP-PTKEY	20	

LFD Data to Billing Company Layout

WA-H-MILEAGE	9	NUMERIC
WA-H-INC-LOC-CITY	30	
WA-H-INC-LOC-ST	2	
WA-H-INC-LOC-ZIP	5	Numeric
WA-H-INC-LOC-CITY-CODE	6	
WA-H-RECEIVE-NAME	30	
WA-H-RECEIVE-ADDR	30	
WA-H-RECEIVE-CITY	30	
WA-H-RECEIVE-ST	2	
WA-H-RECEIVE-ZIP	5	Numeric

Total Record length - 10,777

Hospital Layout

	Field Name	Type	Length	Comments
1	Hospital Medical Record No.	A	19	Medical Record Number
2	Site Indicator	A	1	East = 'E', West = 'W'
3	Admit Date	N	8	YYYYMMDD
4	Admit Time	N	4	HHMM
5	Patient Last Name	A	20	
6	Pt. First Name	A	20	
7	Pt Middle Int	A	1	
8	Pt. Address 1	A/N	30	Pt Address 1
9	Pt. Address 2	A/N	30	Pt Address 2
10	Pt City	A	18	Pt City
11	Pt State	A	2	Pt State
12	Pt Zip Code	N	9	Pt ZIP Code
13	Date of Birth	N	8	YYYYMMDD
14	Gender	A	1	M=Male/F=Female
15	Soc Sec Num	N	9	
16	Race	A	10	
17	Pt Employer	A/N	20	
18	Pt Employment Phone #	N	10	
19	Last Name Contact Person	A	20	Person to Notify
20	First Name	A	20	Person to Notify
21	Person to notify relationship	A	10	Ex: Spouse/Brother
22	Person to Notify Phone #	N	10	
23	Guarantor Last Name	A	20	Guarantor Information
24	Guarantor First Name	A	20	Guarantor Information
25	Guarantor Address 1	A	30	Guarantor Address 1
26	Guarantor Address 2	A	30	Guarantor Address 2
27	Guarantor City	A	18	Guarantor Address
28	Guarantor State	A	2	Guarantor Address
29	Guarantor Zip Code	N	9	Guarantor Address
30	Primary Insurance Company	A	30	Name of Insurance Company
31	Ins Code	A	10	Insurance Company Code
32	Ins Address 1	A/N	30	Insurance Address 1
33	Ins Address 2	A/N	30	Insurance Address 2
34	Ins Co. City	A	18	Insurance Co Address
35	Ins Co. St	A	2	Insurance Co Address

36	Ins Co. Zip Code	N	9	Insurance Co Address
37	Ins Co. Phone Number	N	10	Insurance Co. Phone Number
38	Pt Group Number	A/N	17	Member Group Number
39	Pt Policy Number	A/N	18	Member Identification Number
40	Secondary Ins Company	A	30	Name of Insurance Company
41	Ins Code	A	10	Insurance Company Code
42	Insurance Address 1	A/N	30	Insurance Address
43	Insurance Address 2	A/N	30	Insurance Address
44	Ins Co. City	A	18	Insurance Co Address
45	Ins Co. St	A	2	Insurance Co Address
46	Ins Co. Zip Code	N	9	Insurance Co Address
47	Ins Co. Phone Number	N	10	Insurance Co. Phone Number
48	Pt Group Number	A/N	17	Member Group Number
49	Pt Policy Number	A/N	18	Member Identification Number
50	Tertiary Ins Company	A	30	Name of Insurance Company
51	Ins Code	A	10	Insurance Company Code
52	Insurance Address 1	A/N	30	Insurance Address
53	Insurance Address 2	A/N	30	Insurance Address
54	Ins Co. City	A	18	Insurance Co Address
55	Ins Co. St	A	2	Insurance Co Address
56	Ins Co. Zip Code	N	9	Insurance Co Address
57	Ins Co. Phone Number	N	10	Insurance Co. Phone Number
58	Pt Group Number	A/N	17	Member Group Number
59	Pt Policy Number	A/N	18	Member Identification Number
60	Admit Reason	A	25	Reason for Visit
61	Diagnosis-1	A	7	ICD-9 Code
62	Diagnosis-2	A	7	ICD-9 Code
63	Diagnosis-3	A	7	ICD-9 Code
64	Diagnosis-4	A	7	ICD-9 Code
65	Auto Accident	A	1	Y=Yes
66	Workers Comp	A	1	Y=Yes
67	Primary Ins. – Subr Last Name	A	20	Subscriber's Last Name
68	Primary Ins. – Subr First Name	A	12	Subscriber's First Name
69	Primary Ins. – Subr Middle Initial	A	1	Subscriber's Middle Initial
70	Primary Ins. – Subscriber Date of Birth	N	8	YYYYMMDD

71	Primary Ins. – Subscriber Gender	A	1	M=Male/F=Female
72	Primary Ins. – Subscriber Employer	A	20	Subscriber's Employer
73	Secondary Ins. – Subr Last Name	A	20	Subscriber's Last Name
74	Secondary Ins. – Subr First Name	A	12	Subscriber's First Name
75	Secondary Ins. – Subr Middle Initial	A	1	Subscriber's Middle Initial
76	Secondary Ins. – Subscriber Date of Birth	N	8	YYYYMMDD
77	Secondary Ins. – Subscriber Gender	A	1	M=Male/F=Female
78	Secondary Ins. – Subscriber Employer	A	20	Subscriber's Employer
79	Tertiary Ins. – Subr Last Name	A	20	Subscriber's Last Name
80	Tertiary Ins. – Subr First Name	A	12	Subscriber's First Name
81	Tertiary Ins. – Subr Middle Initial	A	1	Subscriber's Middle Initial
82	Tertiary Ins. – Subscriber Date of Birth	N	8	YYYYMMDD
83	Tertiary Ins. – Subscriber Gender	A	1	M=Male/F=Female
84	Tertiary Ins. – Subscriber Employer	A	20	Subscriber's Employer
85	Fourth Ins Company	A	30	Name of Insurance Company
86	Ins Code	A	10	Insurance Company Code
87	Insurance Address 1	A/N	30	Insurance Address
88	Insurance Address 2	A/N	30	Insurance Address
89	Ins Co. City	A	18	Insurance Co Address
90	Ins Co. St	A	2	Insurance Co Address
91	Ins Co. Zip Code	N	9	Insurance Co Address
92	Ins Co. Phone Number	N	10	Insurance Co. Phone Number
93	Pt Group Number	A/N	17	Member Group Number
94	Pt Policy Number	A/N	18	Member Identification Number
95	Fourth Ins. – Subr Last Name	A	20	Subscriber's Last Name
96	Fourth Ins. – Subr First Name	A	12	Subscriber's First Name
97	Fourth Ins. – Subr Middle Initial	A	1	Subscriber's Middle Initial
98	Fourth Ins. – Subscriber Date of Birth	N	8	YYYYMMDD
99	Fourth Ins. – Subscriber	A	1	M=Male/F=Female

	Gender			
100	Fourth Ins. – Subscriber Employer	A	20	Subscriber’s Employer

City of Lincoln
EMS Call Volume Data
FY 2000-03

Note: Activity is through January 31, 2003

Emergency:

Month	Total Bills	Amount Billed	Contractual Reductions	Collectable Amount	Amount Collected	Collection % of Gross	Collection % of Net	Write Offs	Remaining Accounts Rec	Percent Remaining
FY 2000-01										
September										
October										
November										
December										
January	798	422,516	77,086	345,430	281,281	66.57%	81.43%	52,269	11,880	2.81%
February	820	430,907	72,406	358,501	289,345	67.15%	80.71%	57,898	11,258	2.61%
March	767	406,970	69,311	337,659	266,904	65.58%	79.05%	54,880	15,875	3.90%
April	790	420,555	75,285	345,270	269,905	64.18%	78.17%	64,767	10,598	2.52%
May	852	452,299	76,965	375,334	293,425	64.87%	78.18%	65,416	16,493	3.65%
June	856	447,152	69,660	377,492	294,103	65.77%	77.91%	58,340	25,049	5.60%
July	842	438,502	68,972	369,530	302,321	68.94%	81.81%	48,264	18,945	4.32%
August	845	456,329	73,203	383,126	307,840	67.46%	80.35%	56,307	18,979	4.16%
FY2000-01 Total	6,570	3,475,230	582,888	2,892,342	2,305,124	66.33%	79.70%	458,141	129,077	3.71%
FY 2001-02										
September	874	456,805	73,061	383,744	289,211	63.31%	75.37%	59,876	34,657	7.59%
October	839	439,758	80,258	359,500	285,428	64.91%	79.40%	49,813	24,259	5.52%
November	783	414,895	72,756	342,139	276,495	66.64%	80.81%	40,531	25,113	6.05%
December	781	415,262	75,764	339,498	263,526	63.46%	77.62%	51,429	24,543	5.91%
January	813	427,096	78,415	348,681	276,129	64.65%	79.19%	53,677	18,875	4.42%
February	762	402,448	74,458	327,990	270,342	67.17%	82.42%	35,674	21,974	5.46%
March	839	445,930	75,260	370,670	293,027	65.71%	79.05%	41,680	35,963	8.06%
April	830	435,041	65,994	369,047	248,257	57.07%	67.27%	51,090	69,700	16.02%
May	848	444,511	84,996	359,515	263,470	59.27%	73.28%	40,556	55,489	12.48%
June	860	441,951	81,810	360,141	263,595	59.64%	73.19%	41,711	54,835	12.41%
July	816	424,247	79,860	344,387	240,086	56.59%	69.71%	18,732	85,569	20.17%
August	811	430,656	79,019	351,637	236,896	55.01%	67.37%	17,951	96,790	22.48%
FY2001-02 Total	9,856	5,178,600	921,651	4,256,949	3,206,462	61.92%	75.32%	502,720	547,767	10.58%
FY 2002-03										
September	836	424,218	73,829	350,389	234,662	55.32%	66.97%	7,454	108,273	25.52%
October	814	424,310	67,437	356,873	213,697	50.36%	59.88%	8,004	135,172	31.86%
November	815	423,141	64,648	358,493	193,118	45.64%	53.87%	6,657	158,718	37.51%
December	802	412,074	57,590	354,484	156,161	37.90%	44.05%	2,020	196,303	47.64%
January	509	248,708	1,780	246,928	1,962	0.79%	0.79%	164	244,802	98.43%
February										
March										
April										
May										
June										
July										
August										
FY2002-03 Total	3,776	1,932,451	265,284	1,667,167	799,600	41.38%	47.96%	24,299	843,268	43.64%

City of Lincoln
EMS Call Volume Data
FY 2000-03

Note: Activity is through January 31, 2003

Non-Emergency:

Month	Total Bills	Amount Billed	Contractual Reductions	Collectable Amount	Amount Collected	Collection % of Gross	Collection % of Net	Write Offs	Remaining Accounts Rec	Percent Remaining
FY 2000-01										
September										
October										
November										
December										
January	175	88,732	33,268	55,464	46,383	52.27%	83.63%	2,260	6,821	7.69%
February	183	95,156	36,410	58,746	46,849	49.23%	79.75%	3,294	8,603	9.04%
March	188	93,629	29,506	64,123	50,063	53.47%	78.07%	3,886	10,174	10.87%
April	258	108,543	42,301	66,242	53,537	49.32%	80.82%	3,334	9,371	8.63%
May	236	100,802	39,270	61,532	51,214	50.81%	83.23%	5,251	5,067	5.03%
June	189	91,986	32,459	59,527	38,196	41.52%	64.17%	2,729	18,602	20.22%
July	192	81,457	27,994	53,463	44,002	54.02%	82.30%	945	8,516	10.45%
August	212	90,226	34,375	55,851	44,965	49.84%	80.51%	1,914	8,972	9.94%
FY2000-01 Total	1,633	750,531	275,583	474,948	375,209	49.99%	79.00%	23,613	76,126	10.14%
FY 2001-02										
September	201	98,722	38,556	60,166	48,233	48.86%	80.17%	1,408	10,525	10.66%
October	192	97,756	33,159	64,597	45,482	46.53%	70.41%	4,995	14,120	14.44%
November	180	89,585	27,337	62,248	41,893	46.76%	67.30%	322	20,033	22.36%
December	165	83,053	32,280	50,773	42,268	50.89%	83.25%	2,515	5,990	7.21%
January	226	109,713	41,908	67,805	52,877	48.20%	77.98%	1,925	13,003	11.85%
February	183	89,928	32,873	57,055	46,928	52.18%	82.25%	1,456	8,671	9.64%
March	203	97,989	31,764	66,225	44,423	45.33%	67.08%	2,713	19,089	19.48%
April	216	102,517	30,774	71,743	45,240	44.13%	63.06%	3,031	23,472	22.90%
May	158	78,443	29,859	48,584	32,680	41.66%	67.26%	1,826	14,078	17.95%
June	143	65,330	21,037	44,293	35,257	53.97%	79.60%	791	8,245	12.62%
July	168	81,617	27,253	54,364	38,451	47.11%	70.73%	1,177	14,736	18.06%
August	152	70,069	18,751	51,318	29,438	42.01%	57.36%	1,183	20,697	29.54%
FY2001-02 Total	2,187	1,064,722	365,551	699,171	503,170	47.26%	71.97%	23,342	172,659	16.22%
FY 2002-03										
September	140	56,319	7,250	49,069	21,863	38.82%	44.56%	1,315	25,891	45.97%
October	199	85,725	12,604	73,121	25,322	29.54%	34.63%	916	46,883	54.69%
November	164	74,690	9,466	65,224	20,997	28.11%	32.19%	41	44,186	59.16%
December	188	77,590	6,082	71,508	7,583	9.77%	10.60%	16	63,909	82.37%
January	111	51,893	110	51,783	958	1.85%	1.85%	-	50,825	97.94%
February										
March										
April										
May										
June										
July										
August										
FY2002-03 Total	802	346,217	35,512	310,705	76,723	22.16%	24.69%	2,288	231,694	66.92%

City of Lincoln
EMS Call Volume Data
FY 2000-03

Note: Activity is through January 31, 2003

Total:

Month	Total Bills	Amount Billed	Contractual Reductions	Collectable Amount	Amount Collected	Collection % of Gross	Collection % of Net	Write Offs	Remaining Accounts Rec	Percent Remaining
FY 2000-01										
September										
October										
November										
December										
January	973	511,248	110,354	400,894	327,664	64.09%	81.73%	54,529	18,701	3.66%
February	1,003	526,063	108,816	417,247	336,194	63.91%	80.57%	61,192	19,861	3.78%
March	955	500,599	98,817	401,782	316,967	63.32%	78.89%	58,766	26,049	5.20%
April	1,048	529,098	117,586	411,512	323,442	61.13%	78.60%	68,101	19,969	3.77%
May	1,088	553,101	116,235	436,866	344,639	62.31%	78.89%	70,667	21,560	3.90%
June	1,045	539,138	102,119	437,019	332,299	61.64%	76.04%	61,069	43,651	8.10%
July	1,034	519,959	96,966	422,993	346,323	66.61%	81.87%	49,209	27,461	5.28%
August	1,057	546,555	107,578	438,977	352,805	64.55%	80.37%	58,221	27,951	5.11%
FY2000-01 Total	8,203	4,225,761	858,471	3,367,290	2,680,333	63.43%	79.60%	481,754	205,203	4.86%
FY 2001-02										
September	1,075	555,527	111,617	443,910	337,444	60.74%	76.02%	61,284	45,182	8.13%
October	1,031	537,514	113,417	424,097	330,910	61.56%	78.03%	54,808	38,379	7.14%
November	963	504,480	100,093	404,387	318,388	63.11%	78.73%	40,853	45,146	8.95%
December	946	498,315	108,044	390,271	305,794	61.37%	78.35%	53,944	30,533	6.13%
January	1,039	536,809	120,323	416,486	329,006	61.29%	79.00%	55,602	31,878	5.94%
February	945	492,376	107,331	385,045	317,270	64.44%	82.40%	37,130	30,645	6.22%
March	1,042	543,919	107,024	436,895	337,450	62.04%	77.24%	44,393	55,052	10.12%
April	1,046	537,558	96,768	440,790	293,497	54.60%	66.58%	54,121	93,172	17.33%
May	1,006	522,954	114,855	408,099	296,150	56.63%	72.57%	42,382	69,567	13.30%
June	1,003	507,281	102,847	404,434	298,852	58.91%	73.89%	42,502	63,080	12.43%
July	984	505,864	107,113	398,751	278,537	55.06%	69.85%	19,909	100,305	19.83%
August	963	500,725	97,770	402,955	266,334	53.19%	66.10%	19,134	117,487	23.46%
FY2001-02 Total	12,043	6,243,322	1,287,202	4,956,120	3,709,632	59.42%	74.85%	526,062	720,426	11.54%
FY 2002-03										
September	976	480,537	81,079	399,458	256,525	53.38%	64.22%	8,769	134,164	27.92%
October	1,013	510,035	80,041	429,994	239,019	46.86%	55.59%	8,920	182,055	35.69%
November	979	497,831	74,114	423,717	214,115	43.01%	50.53%	6,698	202,904	40.76%
December	990	489,664	63,672	425,992	163,744	33.44%	38.44%	2,036	260,212	53.14%
January	620	300,601	1,890	298,711	2,920	0.97%	0.98%	164	295,627	98.35%
February	-	-	-	-	-	-	-	-	-	-
March	-	-	-	-	-	-	-	-	-	-
April	-	-	-	-	-	-	-	-	-	-
May	-	-	-	-	-	-	-	-	-	-
June	-	-	-	-	-	-	-	-	-	-
July	-	-	-	-	-	-	-	-	-	-
August	-	-	-	-	-	-	-	-	-	-
FY2002-03 Total	4,578	2,278,668	300,796	1,977,872	876,323	38.46%	44.31%	26,587	1,074,962	47.18%

Lincoln Fire Rescue Call Volume

ATTACHMENT G

Call Volume	Jan-01	Feb-01	Mar-01	Apr-01	May-01	Jun-01	Jul-01	Aug-01	Sep-01	Oct-01	Nov-01	Dec-01	Jan-02	Feb-02	Mar-02	Apr-02	May-02	Jun-02	Jul-02	Aug-02	Sep-02	Oct-02	Nov-02	Dec-02	Jan-03	Totals
Mileage	6475	6586	6435	6938	8004	8121	6107	5795	7026	7465	6261	5812	6112	5874	7002	7681	6552	5539	5993	5542	5508	6696	7044	6021	3678	160,267
Non-Emergency Transports	175	182	183	256	232	186	178	202	193	181	169	163	222	175	199	211	154	139	162	146	131	195	161	185	109	4,489
ALS Emergency Transports	576	254	354	451	458	443	445	440	452	401	440	460	425	414	417	478	419	467	452	436	463	453	468	458	283	10,807
BLS Emergency Transports	158	494	346	263	320	300	297	321	310	335	234	245	297	260	331	286	326	274	268	287	269	279	247	262	184	7,193
ALS 2 and Specialty Care Transports	34	39	22	23	21	29	35	27	38	40	52	36	38	44	43	30	47	34	31	35	37	34	45	38	23	875
ALS Paramedic Intercepts	9	10	12	19	7	18	10	12	12	18	14	12	20	10	28	13	15	20	13	20	12	19	8	16	9	356
ALS Treat & Release	12	3	20	19	16	15	15	16	15	12	16	13	23	16	11	14	6	11	18	13	15	18	14	11	9	351
Standby	9	20	13	15	30	51	40	29	47	33	27	15	10	18	9	9	35	54	34	20	40	38	33	17	0	646
Team Transports	0	1	5	2	4	3	14	10	8	11	11	2	4	8	4	5	4	4	6	6	9	4	3	3	3	134
Transport Totals:	973	1003	955	1048	1088	1045	1034	1057	1075	1031	963	946	1039	945	1042	1046	1006	1003	984	963	976	1040	979	990	620	24,851

Note: Call volume does not include all transports done, only calls billed out as of Feb 6, 2003.

Collection Agency Record Layout

Incident Information	Comments
Incident #	
Patient #	
Billing Company Account Number	
Date of Service	
Incident Location Address 1	(Pick up Address)
Incident Location Address 2	
Incident Location City	
Incident Location State	
Incident Location Zip	
Receiving Facility Name	
Receiving Facility Address 1	
Receiving Facility Address 2	
Receiving Facility City	
Receiving Facility State	
Receiving Facility Zip	
Charge Information	
Service Description 1 / Qty / Amount	Separated out for transports, etc ...
Service Description 2 / Qty / Amount	Mileage, etc ...
Service Description 3 / Qty / Amount	Finance charges, etc...
Service Description 4 / Qty / Amount	
Original Amount Owed	
Balance	
Date of Last payment	
Patient Information	
Patient Last Name	
Patient First Name	
Patient Middle Initial	
Patient Address 1	

Date Revised: February 11, 2003

Patient Address 2	
Patient City	
Patient State	
Patient Zip Code	
Patient Phone Number	
Pt Date of Birth	
Pt Social Security Number	
Employer Information	
Pt. Employer	
Pt. Employment Phone #	
Contact Person's Information:	
Last Name	(Person to Notify)
First Name	
Relationship to patient	Ex: Spouse/Brother
Person to Notify Phone #	
Guarantor Information	
GU Last Name	
GU First Name	
GU Address 1	
GU Address 2	
GU City	
GU State	
GU Zip Code	
GU Date of Birth	
GU Social Security Number	
GU Employer	
GU Employer Telephone Number	
GU Telephone Number	
Revenue Center	
Patient Notes	

Definition of Policy

To define when an ambulance transport service fee will be turned over for further collection process or written off as un-collectable.

Implemented 0/00

Purpose

The purpose of this policy is to define when an ambulance transport service fee will be turned over to the collection agency chosen by the department or when the fee will be written off as un-collectable.

Policy

It is the policy of the department that every effort will be made to collect a fee for service when ambulance transportation services are provided. This policy includes an additional finance charge following the schedule below. The additional finance charge will not apply to accounts such as corporations & organizations handling the affairs of various patients, nor will finance charges apply to standby services or intercept services provided by Lincoln Fire to rural communities based on approved agreements.

Procedure

The billing service provider selected by the department shall submit a statement of account to the responsible party, either a third party, or directly to the customer. The first bill will be generated within three working days of receipt of basic charge record.

For balances due by the patient

Day 1:

1st statement is mailed within 5 business days of bill being generated. Notification on statement will state 1.5% finance charge if not paid within 30 days.

Day 30:

2nd statement is sent with 1.5% finance charge

Day 60:

3rd statement is sent with 1.5% finance charge and notice that the account will be sent to collections within 10 days if no contact is made. Notification of additional charges for collections is also stated.

Day 80:

Patient account is turned over to the city for further collection process

Lincoln Fire & Rescue - Management Policy
Collection and Write-off Policy (MP000.00 3/01)

Definition of Policy

To define when an ambulance transport service fee will be turned over for further collection process or written off as un-collectable.

Implemented 0/00

For balances due by an insurance company

Day 1:

Claim is submitted electronically if the insurance company allows. If the insurance company does not accept electronic claim filing, the claim will be mailed first class mail. Claim is to be submitted either electronically or mailed to the insurance company within 3 business days of receipt of basic charge record.

Day 45:

Follow up phone call to the insurance company, with results of the conversation being documented in patient account notes.

Day 90:

Follow up phone call to the insurance company, with results of the conversation being documented in patient account notes.

Day 120:

Follow up phone call to the insurance company, with results of the conversation being documented in patient account notes. Follow-up with the insurance company will occur every 30-45 days after this date with documentation of results placed in patient account notes.

The billing service provider selected by the department shall be allowed to make the following adjustments without prior notification to Lincoln Fire & Rescue:

1. Insurance adjustments due to exceeding the allowable charge
2. Small Balance for accounts with total balance of less than \$10.00
3. Accounts in Medicaid financial class in a State which we do not have a provider number
4. Refunds on accounts due to overpayments
5. Interest payments if payment is made within 7 days of interest charge being assessed

Lincoln Fire & Rescue - Management Policy
Collection and Write-off Policy (MP000.00 3/01)

Definition of Policy

To define when an ambulance transport service fee will be turned over for further collection process or written off as un-collectable.

Implemented 0/00

The billing service provider selected by the department shall notify Lincoln Fire & Rescue prior to any adjustment for the following reasons:

1. Untimely Filing
2. Deceased, no estate or insurance
3. Non-covered services
4. Request from patients for adjustments for other reasons than listed above
5. Bankruptcy

Payments received by billing provider after account has been turned over to the city for further collections should be reported to the EMS Business Manager. Determination on processing payment will be made case by case.

SAMPLE RUN REPORTS

See Question #26 of Questionnaire

Patient Care Report
Lincoln Fire & Rescue
City of Lincoln

				Times	Response Analysis
Action Taken 07 MEDICAL	Level 01 BLS	Refusal 01 NOT APPLI	Dispatch Notified 10:54:50	Dispatch 01:35:38	
Scene Address	Rm	Location Type	Unit Notified 12:30:28	Chute 00:00:05	
1234 S ANYWHERE ST		331 HOSPITAL	Unit Enroute 12:30:33	To Scene 00:13:25	
LINCOLN, NE		Response Code to Scene	Arrived Scene 12:43:53	At Scene 00:24:39	
		03 NON-EMERGENCY (CODE 1)	Enroute Dest 13:08:32	Transport 00:10:56	
			Arrived Dest 13:19:28	At Dest 00:08:21	
			Back in Service 13:27:49	Tot Time 00:57:21	
				Loaded M1 3.6	

Patient # 0001	Name FROG, KERMIT T	SSN	Gender MALE	DOB 01/01/19
Address 0	City LINCOLN	St NE	Zip	Phone
Race 01 CAUCASIAN	Age 84 Yrs 0 Mos	Weight:	Patient Key # 333333	
Dispatched As 66 ROUTINE TRANSFER	Trauma Injury? NO			
Chief Complaint 55 NO COMPLAINT	Glasgow Coma Scale:		Trauma Scale:	
Provider Impression 998 N.O.S. - NOT OT	Location:		Vehicle Info:	
	Safety Device:		Ejected:	

Patient Medical History	Current Medications	Allergies
HTN BILAT AKA VERTIGO	ASA CLONIDINE	NKMA

Injury/Illness Detail		
Type	Major Area	Minor Area
998 N.O.S. - NOT OTHERWISE SPECIFIED	03 HEAD	31 SCALP / BRAIN / CNS

Vitals									
Severity	Pupils	Chest	Skin Moisture	Skin Color	Abdomen	Temp	APGAR	Burn %	02 Sat
01 MINOR - VIT NOT OBTAINED		99 NOT OBTAINED	01 NORMAL	01 NORMAL	99 NOT OBTAINED				
Time	Position	Pulse	L.O.C.	Resp	BP	Rhythm			
13:08	02 SITTING	0070	01 CONSCIOUS - ALERT	16	136/060	98 NOT OBTAINED			
13:18	02 SITTING	0070	01 CONSCIOUS - ALERT	16	130/064	98 NOT OBTAINED			

Treatments		Actions/Medications							
Procedure	Unit Id	Time	Action/Medication	Att.	Amt.	Emp Id	Effect		
99 NONE									

Disposition			
Control Hospital 00 NOT APPLICABLE	Mode of Transport 01 AMBULANCE		
Transported To	Dest Determined By CHOICE		
Address	St	Zip	

Comments

Patient: Kermit T. Frog

Dispatched on an Omega response from Hospital A to Nursing Home. Arrived to find an 84 year old male sitting upright in the ER bed. Patient had been seen for dizziness and diagnosed with vertigo. Patient is now ready to be returned to place of residence at the nursing home. Patient is COAX3, has no verbal complaints at this time. Patient is unable to ambulate secondary to bilat AKA. However, patient is mobile via use of wheelchair per patient. Transferred the patient from bed to cot via sheet draw x 2 without incident. No problems enroute. Patient fell asleep during transport however was easily aroused with voice. No change in patient's condition noted while enroute. Transported patient without incident. Transferred the care to staff, report given.

Physician's Medical Necessity
Certification

PCS

For Non-Emergency Scheduled and
Unscheduled Medical Transportation Services

Unit ID#:

M

Incident #:

Name: Last Name <u>Frog</u> First Name <u>Hermit</u> Middle Initial <u>T.</u>		Date of Certification:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:	Age:
Medicare No:		Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medicaid No:		

OPTION 1

☒ In my professional medical opinion, this patient requires transport by ambulance and should not be transported by other means. The patient's condition is such that transportation by medically trained personnel is required. The Medicare definition of Bed Confined for non-emergency ambulance transportation is: The inability to get up from bed without assistance and the inability to ambulate and the inability to sit in a chair, including wheelchair.

Does the patients condition meet Medicare's definition of Bed Confined? ☒ YES ☐ NO

If the patient does not meet bed confined criteria as defined above, can this patient be safely transported by wheelchair van? ☐ YES ☒ NO

If NO, please check the appropriate medical conditions listed below which would be necessitate transported by ambulance.

<input type="checkbox"/> Requires continuous oxygen and monitoring by trained staff <input type="checkbox"/> Required airway monitoring or suctioning <input type="checkbox"/> Requires restraints or sedation <input type="checkbox"/> Comatose & requires trained monitoring <input type="checkbox"/> Had to remain immobile because of a fracture or possibility of a fracture which had not been set <input type="checkbox"/> Patient is ventilator dependent and/or requires mechanical ventilation (BVM) <input type="checkbox"/> Contractures	<input type="checkbox"/> Has decubitus ulcers & requires precautions <input type="checkbox"/> Requires isolation precautions <input type="checkbox"/> Patient requires continuous IV therapy <input type="checkbox"/> Requires continuous cardiac monitoring <input type="checkbox"/> Is exhibiting signs of a decreased level of consciousness <input type="checkbox"/> Is on hip precautions and cannot sit safely <input checked="" type="checkbox"/> Other (explain) <u>Rt Bilat LE amputee -</u> <u>Can not transfer or ambulate</u>
--	--

OPTION 2

☐ In my professional medical opinion, this patient does not require transport by ambulance and can safely be transported by other means.

☐ Patient can safely support him/herself while seated in wheelchair and does not require monitoring by trained personnel

☐ Patient is able to tolerate transportation by automobile or wheelchair van.

Print the ordering Physician's Name here. Sesame Street, MD UPIN: _____

Physician's signature: Sesame Street, MD Date: Anytime 2003

I certify that the above information represents an accurate assessment of the patient's medical condition(s). I understand that this information will be used by the Health Care Financing Administration to support the determination of medical necessity for ambulance service.

Doctors order taken by: _____ Date: ____/____/____

Without a complete form, the patient will not receive Medicare benefits for ambulance transportation.

Please give completed form to the ambulance crew at the time of transport, or fax to Lincoln Fire & Rescue at (402) 441-3832

**Patient Care Report
Lincoln Fire & Rescue
City of Lincoln**

			Times	Response Analysis
Action Taken 07 MEDICAL	Level 01 BLS	Refusal 01 NOT APPLI	Dispatch Notified 09:24:35	Dispatch 03:06:14
Scene Address	Rm	Location Type	Unit Notified 12:30:49	Chute 00:02:08
12345 NOWHERE ST		331 HOSPITAL	Unit Enroute 12:32:57	To Scene 00:11:14
LINCOLN, NE		Response Code to Scene	Arrived Scene 12:42:03	At Scene 00:39:36
		03 NON-EMERGENCY (CODE 1)	Enroute Dest 13:21:39	Transport 00:12:02
			Arrived Dest 13:33:41	At Dest 00:08:44
			Back in Service 13:42:25	Tot Time 01:11:36
				Loaded M1 4.0

Patient # 0001	Name BIRD, BIG H	SSN	Gender MALE	DOB 01/01/19
Address 0	City LINCOLN	St NE	Zip	Phone
Race 01 CAUCASIAN	Age 84 Yrs 0 Mos	Weight:	Patient Key # 333333	
Dispatched As 66 ROUTINE TRANSFER	Trauma Injury? NO			
Chief Complaint 22 WEAKNESS, GENERALIZED	Glasgow Coma Scale:		Trauma Scale:	
Provider Impression 87 NON-AMBULATORY	Location:		Vehicle Info:	
	Safety Device:		Ejected:	

Patient Medical History	Current Medications	Allergies
ASPIRATION PNEUMONIA CVA A-FIB SEIZURES	ASA CARDIZEM TEGRETOL	UNK

Injury/Illness Detail		
Type	Major Area	Minor Area
87 NON-AMBULATORY	06 EXTREMITIES	61 LEGS

Vitals									
Severity	Pupils	Chest	Skin Moisture	Skin Color	Abdomen	Temp	APGAR	Burn %	02 Sat
01 MINOR - VIT NOT OBTAINED		99 NOT OBTAINED	01 NORMAL	01 NORMAL	99 NOT OBTAINED				

Time	Position	Pulse	L.O.C.	Resp	BP	Rhythm
13:21	02 SITTING	0084	04 CONSCIOUS - CONFUSED,	24	158/P	98 NOT OBTAINED
13:32	02 SITTING	0078	04 CONSCIOUS - CONFUSED,	24	156/P	98 NOT OBTAINED

Treatments		Actions/Medications				
Procedure	Unit Id	Time	Action/Medication	Att.	Amt.	Emp Id Effect
99 NONE						

Disposition		
Control Hospital 00 NOT APPLICABLE	Mode of Transport 01 AMBULANCE	
Transported To	Dest Determined By CHOICE	
Address	St	Zip
Comments		

Patient: Big H. Bird

Dispatched Omega to transfer the patient from Hospital A to Nursing Home. Patient is non-ambulatory due to CVA. Patient is on room air, conscious but confused. Patient has Foley cath in place. Patient is to be transferred back to the nursing home for continued care. Patient was 4 person lifted on sheet to bed, placed semi sitting on cot and moved to the ambulance. Transferred to nursing home without incident or change. 4 person lifted on sheet to bed. Patient was left in the care of RN.

GENERAL INFORMATION SECTION

Name of Transferring Facility: Hospital

Transferred to: Nursing Home

Address: _____

Address: _____

City, State: _____

City, State: _____

Dates of Stay at Transferring Facility: Adm. Dt: _____ Transfer Dt: _____

Mode of Transportation: _____ By Whom: _____

PATIENT'S LAST NAME <u>Bird,</u>		FIRST <u>Big</u>	INIT. _____	MEDICAID NO. _____	SOC. SEC. NO. _____	MEDICARE NO. _____	
ADDRESS: STREET _____		CITY _____	STATE _____	ZIP _____	BIRTH DATE _____	MARITAL STATUS S M D W Sep	RELIGION _____
Home Telephone: _____			Age: _____	Sex: _____	County of Residence: _____		

PATIENT NEEDS / CONCERNS / DISCHARGE SUMMARY:

Personality Characteristics

Brief explanation of why transferred for care: i.e., coded, bleeding, recent fall, etc.

Pt admitted with aspiration pneumonia. Hx CVA 9 mths ago. G-Tube, J-Tube with T.F. \emptyset Verbal, does not follow commands, rt arm flaccid, left arm et L.E. with random movements. Foley, incont. Bm. LS DIM sec moist NP cough. O_2 sat 90% Room air. Blood cultures (+) for E. coli on Im Reception

LAST STOOL

Continence:

	Yes	No
Bowel	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Bladder	<input type="checkbox"/>	<input checked="" type="checkbox"/>

BEHAVIOR

☒ Cooperative
☐ Uncooperative

DISABILITIES / IMPAIRMENTS:

<input checked="" type="checkbox"/> Mental	<input type="checkbox"/> Speech	<input type="checkbox"/> Hearing
<input type="checkbox"/> Vision	<input type="checkbox"/> Sensation	<input type="checkbox"/> Ambulation
Amputation:		
Leg:	<input type="checkbox"/> Rt.	<input type="checkbox"/> Lt.
Arm:	<input type="checkbox"/> Rt.	<input type="checkbox"/> Lt.
Paralysis:	<input type="checkbox"/> Rt. Side	<input type="checkbox"/> Quadriplegia
	<input type="checkbox"/> Lt. Side	<input type="checkbox"/> Paraplegia
Contractures:	<input type="checkbox"/> Rt. Arm	<input type="checkbox"/> Rt. Leg
	<input type="checkbox"/> Lt. Arm	<input type="checkbox"/> Lt. Leg
	<input type="checkbox"/> Neck	

MENTAL STATUS:

☐ Alert ☒ Non-responsive
☐ Occasionally Confused ☐ Confused
Describe any recent changes in mental status _____

COMMUNICATION ABILITY:

	Yes	No	Unknown
Can Speak	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Yes	No	Unknown
Understands Speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Language Spoken (other than English) _____			

SOCIAL INFORMATION: Prior to present, Pt. lived:

☐ Alone ☒ Nursing home ☐ With friends
☐ Other ☐ With family ☐ Assisted Living

ATTACHMENTS:

<input checked="" type="checkbox"/> Lab	<input type="checkbox"/> Surgical Report
<input checked="" type="checkbox"/> Progress Notes	<input type="checkbox"/> Legal Guardianship
<input type="checkbox"/> Consultations	<input type="checkbox"/> Durable P.O.A.
<input checked="" type="checkbox"/> PT Notes	<input type="checkbox"/> Health Care P.O.A.
<input checked="" type="checkbox"/> H&P (Current)	<input type="checkbox"/> Living will (Terminally ill Declaration)
<input type="checkbox"/> Discharge	<input type="checkbox"/> Other _____

PERSONAL VALUABLES:

☐ Dentures ☐ Watch
☐ Eyeglasses ☐ Rings
☐ Clothes ☐ Other (Specify) _____

RESPONSIBLE PARTY / LEGAL GUARDIAN:

Name: _____
Relationship: _____ Notification made ☐ Yes ☐ No
Address: _____
City, State: _____ Phone: _____

PHYSICIAN / CLINIC APPOINTMENT

Date: _____
Time: _____

ATTENDING PHYSICIAN AT TIME OF TRANSFER

Name: _____
Phone: _____

Sesame Street RN Anytime 200
Signature (Nurse) Title Date

COMMUNITY-WIDE TRANSFER FORM

PHYSICIANS ORDERS SECTION

Patient's Name Bird, Big

Allergies:

MEDICATIONS NAME	DOSAGE	ROUTE	TIME	FREQUENCY	LAST DOSE GIVEN DATE & TIME	DIAGNOSIS (REQUIRED)
Aspirin	81mg			QD		
Cardizem	60mg			TID		
Amiodarone	200mg			QD		
Troxetol SUSP	5ml			BID		
Zantac Syrup	30mg			QHS		
Plavix	75mg			QD		
Insulin NPH	50U			BID		
Rocphin	1gram					
Insulin Regular	4U					
	8U					
	12U					
	16U					
	20U					
Tylenol 500mg	1-2 tabs			PRN		
m.d.m.	30cc					
Albuterol	1mg					
Albuterol 0.5cc/Albuterol						

PRIMARY & SECONDARY DIAGNOSIS: Include surgical procedures & dates

Admitted with aspiration pneumonia, Hx of CVA 9 mths ago, Hx Afib, seizures, diabetes, G-tube, J-Tube, HTN

TREATMENT & OTHER ORDERS: Dressing changes, Observation, Teaching, Procedures, Radiology, Laboratory, etc.

Flush PEG Tube to 30 cc H₂O QID
Blood Sugars QID

IV Site _____ Gauge _____ Date of insertion _____ O₂ _____ l/min ☐ Mask ☐ Nasal prong ☒ PRN ☐ Continuous

Open areas ☐ Yes ☒ No Describe site & size _____

☐ Ted Hose ☐ Jobst Stockings: ☐ RT ☐ LT ☐ BIL ☐ Knee high ☐ Thigh high Removal frequency _____

Foley Catheter: ☒ Foley size 16Fr Date last changed _____ Diagnosis for catheter _____

ACTIVITY ORDERS:

☐ Activity as tolerated ☐ Other _____

Patient uses: ☐ Wheelchair ☐ Cane ☐ Walker ☐ Crutches ☐ Equipment/Supplies _____

Weight Bearing: ☐ Full ☐ Partial ☐ _____ #s ☐ RT ☐ LT ☒ None

DISCIPLINES: Evaluation and Treatment

☒ Skilled Nurse

frequency/order _____

☐ Speech Therapy

frequency/order _____

☐ Physical Therapy

frequency/order _____

☒ Respiratory Therapy

frequency/order Wali, Fr

☐ Occupational Therapy

frequency/order _____

☐ Home Health Aide

frequency/order _____

DIET:

NPO, Tube feedings Perative (impact) Full Strength via J Tube ☐ CODE ☐ NO CODE

* History & Physical is current: ☐ Yes ☐ No "Hospital H&P is current per progress notes pending availability of final summary and discharge diagnosis."

REHABILITATION POTENTIAL: EXPECTED, NEXT 12 MONTHS

☐ Improve ☐ Remain Static ☐ Deteriorate

LEVEL OF CARE: ☐ Skilled ☒ Skilled Medicare ☐ Skilled Medicaid ☐ ICF/MR

☐ Acute ☐ Nursing Facility ☐ Assisted Living "I certify that extended care facility (ECF) services are required on an inpatient, continuous basis due to the current medical condition(s) in this document."

TRANSPORTATION REQUIREMENTS:

☐ Patient can be transported in wheelchair.

☒ Patient must be transported by ambulance because (check one or both):

☒ Patient is unable to get up from bed without assistance, is unable to ambulate, and is unable to ride in a wheelchair.

☐ Medical observation is required enroute.

PATIENT KNOWS DIAGNOSIS: ☐ Yes ☐ No If No, why? _____

SIGNATURE OF PHYSICIAN: Sesame Street, MD

DATE: Anytime 2003

Patient Care Report
Lincoln Fire & Rescue
City of Lincoln

Action Taken 07 MEDICAL				Level 01 BLS	Refusal 01 NOT APPLI	Times		Response Analysis	
Scene Address				Rm	Location Type	Dispatch Notified 19:59:45		Dispatch 00:00:16	
12345 E ANYWHERE ST					965 PARKING AREA, UNCOVERED	Unit Notified 20:00:01		Chute 00:00:26	
LINCOLN, NE					Response Code to Scene	Unit Enroute 20:00:27		To Scene 00:05:59	
					01 EMERGENCY(CODE 3)	Arrived Scene 20:06:00		At Scene 00:07:58	
						Enroute Dest 20:13:58		Transport 00:07:43	
						Arrived Dest 20:21:41		At Dest 00:00	
						Back in Service 00:00:00		Tot Time 00:00	
								Loaded M1 2.3	

Patient # 0001	Name ELMO, FUN	SSN	Gender FEMALE	DOB 01/01/19
Address 0	City LINCOLN	St NE	Zip	Phone
Race 01 CAUCASIAN	Age 84 Yrs 0 Mos	Weight:	Patient Key # 333333	
Dispatched As 18 FALL		Trauma Injury? YES		17 FALL < 15 FEET
Chief Complaint 50 PAIN/DISCOMFORT		Glasgow Coma Scale: 0015 0015		Trauma Scale: 0012
Provider Impression 59 FRACTURE		Location:		Vehicle Info:
		Safety Device:		Ejected:

Patient Medical History	Current Medications	Allergies
HTN OSTEOARTHRITIS DEPRESSION	METOPROLOL EFFOXOR ADECAN	PCN DISOTECH

Injury/Illness Detail		
Type	Major Area	Minor Area
59 FRACTURE	05 TORSO	58 PELVIS / GENITOURINARY

Vitals									
Severity	Pupils	Chest	Skin Moisture	Skin Color	Abdomen	Temp	APGAR	Burn %	02 Sat
05 MODERATE -	P.E.A.R.L.	01 BOTH CLEAR	01 NORMAL	01 NORMAL	01 NORMAL				
Time	Position	Pulse	L.O.C.	Resp	BP	Rhythm			
20:08	03 LYING	0076	01 CONSCIOUS - ALERT	24	152/080	98 NOT OBTAINED			
20:13	02 SITTING	0076	01 CONSCIOUS - ALERT	24	180/064	98 NOT OBTAINED			
20:21	02 SITTING	0076	01 CONSCIOUS - ALERT	24	178/P	98 NOT OBTAINED			

Treatments		Actions/Medications				
Procedure	Unit Id	Time	Action/Medication	Att.	Amt.	Emp Id Effect
18 O2 GIVEN BY OXYGEN CANNULA						
51 PILLOW SPLINT						

Disposition			
Control Hospital 00 NOT APPLICABLE	Mode of Transport 01 AMBULANCE		
Transported	Dest Determined By DIVERSION		
Address	LINCOLN	St	Zip
Comments			

Patient: Fun Elmo

Dispatched Alpha to a fall. Arrived to find an 84 year old lying supine on the pavement of a parking lot in care of bystanders and the engine company. Conx-Alert-Oriented x 4. Complaining of right hip pain. Distal MSC intact. Patient reports she was walking across a parking lot that was slopped down and she began to fall forward, landing on her right hip. Patient denies any loss of consciousness. Not complaining of any neck or back pain, dyspnea, nausea or dizziness. Vitals as reported. Moved patient to cot and pillow was placed under patient knees for support. MSC remains intact. Moved to Ambulance. Transport to Hospital A per diversion policy. Still complaining of right hip pain. No new complaints enroute. Arrived MSC intact. Transferred to ER bed and report given to ER RN.

Patient Care Report
Lincoln Fire & Rescue
City of Lincoln

Action Taken 07 MEDICAL			Level 01 BLS	Refusal 01 NOT APPLI	Dispatch Notified 14:08:08	Response Analysis
Scene Address			Rm	Location Type	Unit Notified 15:30:54	Dispatch 01:22:46
12345 W ANYWHERE ST				331 HOSPITAL	Unit Enroute 15:31:09	Chute 00:00:15
LINCOLN, NE				Response Code to Scene	Arrived Scene 15:46:01	To Scene 00:15:07
				03 NON-EMERGENCY (CODE 1)	Enroute Dest 16:12:48	At Scene 00:26:47
					Arrived Dest 16:21:53	Transport 00:09:05
					Back in Service 16:29:21	At Dest 00:07:28
						Tot Time 00:58:27
						Loaded Ml 2.8

Patient # 0001	Name BERT, YELLOW	SSN	Gender FEMALE	DOB 01/01/19
Address 0	City LINCOLN	St NE	Zip	Phone
Race 01 CAUCASIAN	Age 84 Yrs	0 Mos	Weight:	Patient Key # 333333

Dispatched As 66 ROUTINE TRANSFER	Trauma Injury? NO	
Chief Complaint 55 NO COMPLAINT	Glasgow Coma Scale:	Trauma Scale:
Provider Impression 998 N.O.S. - NOT OT 998 N.O.S. - NOT OT	Location:	Vehicle Info:
	Safety Device:	Ejected:

Patient Medical History	Current Medications	Allergies
RESP FAILURE/HTN/COPD OBESITY/PERIPHERAL EDEMA PLEURAL EFFUSION/CORPULMO GERD/PULMONARY HTN/RENAL	FFICENCY ENALAPRIL ZANTAC ASA DUONBBS	NKMA

Injury/Illness Detail

Type	Major Area	Minor Area
998 N.O.S. - NOT OTHERWISE SPECIFIED	05 TORSO	52 LUNGS
998 N.O.S. - NOT OTHERWISE SPECIFIED	05 TORSO	51 HEART

Vitals

Severity	Pupils	Chest	Skin Moisture	Skin Color	Abdomen	Temp	APGAR	Burn %	02 Sat
01 MINOR - VIT NOT OBTAINED		99 NOT OBTAINED	01 NORMAL	01 NORMAL	99 NOT OBTAINED				

Time	Position	Pulse	L.O.C.	Resp	BP	Rhythm
16:12	03 LYING	0999	01 CONSCIOUS - ALERT	24	999/999	98 NOT OBTAINED
16:21	03 LYING	0999	01 CONSCIOUS - ALERT	24	999/999	98 NOT OBTAINED

Treatments

Actions/Medications

Procedure	Unit Id	Time	Action/Medication	Att.	Amt.	Emp Id	Effect
18 O2 GIVEN BY OXYGEN CANNULA							

Disposition

Control Hospital 00 NOT APPLICABLE

Mode of Transport 01 AMBULANCE

Transported To

Dest Determined By CHOICE

Address 1234 W NOWHERE ST

LINCOLN

St NE Zip 68511

Comments

Patient: Yellow Bert

Dispatched on Omega response from Hospital B to private residence. Arrived to find a female patient lying semi fowlers in bed with 02 via NC. Foley cath in room. Patient was seen for increasing SOB. Patient has chosen to DC all interventions. Refusing vital signs, assessments and treatments. Patient has chosen to return home. Patient is COAX3, no complaints at this time. Patient weight is approx 144 kgs. Patient transferred from bed to cot via sheet draw x6 without incident or problems. Patient is able to ambulate very short distances and is full weight bearing. Enroute the patient refuses vital signs to be taken and assessment. Only vital sign able to obtain would be respirations. Patient continues to be on 02 via NC at 3LPM. No change in patient's condition noted while enroute. Transported patient without incident, no problems. Upon arrival at patient's residence, the engine company was on location to assist with lifting and moving patient into residence, which was done without incident or problems.

GENERAL INFORMATION SECTION

Name of Transferring Facility: Hospital

Transferred to: Residence

Address: _____

Address: _____

City, State: _____

City, State: _____

Dates of Stay at Transferring Facility: Adm. Dt: _____ Transfer Dt: _____

Mode of Transportation: _____ By Whom: _____

PATIENT'S LAST NAME <u>Bert,</u>		FIRST <u>Yellow</u>	INIT. _____	MEDICAID NO. _____	SOC. SEC. NO. _____	MEDICARE NO. _____
ADDRESS: STREET _____		CITY _____	STATE _____	ZIP _____	BIRTH DATE _____	MARITAL STATUS S M D W Sep _____
Home Telephone: _____		Age: _____	Sex: _____	County of Residence: _____		

PATIENT NEEDS / CONCERNS / DISCHARGE SUMMARY:

Personality Characteristics

Brief explanation of why transferred for care: i.e., coded, bleeding, recent fall, etc.

Increasing SOB, approximate 40 LB weight gain recently. unable to walk or get out of bed. Increasing somnolence and confusion. Echo EF 37% 2) Thoracentesis 3 days ago with no improvement
O2 3L Inc desats frequently
2+ edema generalized.

Pt Refuses VS, assessments & treatments

Temp _____ Pulse _____ Resp 20 BP _____ WT 144

PERSONAL VALUABLES:

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Watch |
| <input type="checkbox"/> Eyeglasses | <input type="checkbox"/> Rings |
| <input type="checkbox"/> Clothes | <input type="checkbox"/> Other (Specify) _____ |

RESPONSIBLE PARTY / LEGAL GUARDIAN:

Name _____
Relationship: _____ Notification made ☐ Yes ☐ No
Address _____
City, State: _____ Phone: _____

PHYSICIAN / CLINIC APPOINTMENT

Date _____
Time: _____

ATTENDING PHYSICIAN AT TIME OF TRANSFER

Name: _____
Phone: _____

LAST STOOL

Continence:

	Yes	No
Bowel	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Bladder	<input type="checkbox"/>	<input checked="" type="checkbox"/>

BEHAVIOR

- ☒ Cooperative
☐ Uncooperative

DISABILITIES / IMPAIRMENTS:

- | | | |
|---------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Mental | <input type="checkbox"/> Speech | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Sensation | <input type="checkbox"/> Ambulation |
| Amputation: | | |
| Leg: | <input type="checkbox"/> Rt. | <input type="checkbox"/> Lt. |
| Arm: | <input type="checkbox"/> Rt. | <input type="checkbox"/> Lt. |
| Paralysis: | <input type="checkbox"/> Rt. Side | <input type="checkbox"/> Quadriplegia |
| | <input type="checkbox"/> Lt. Side | <input type="checkbox"/> Paraplegia |
| Contractures: | <input type="checkbox"/> Rt. Arm | <input type="checkbox"/> Rt. Leg |
| | <input type="checkbox"/> Lt. Arm | <input type="checkbox"/> Lt. Leg |
| | <input type="checkbox"/> Neck | |

MENTAL STATUS:

- ☒ Alert ☐ Non-responsive
☒ Occasionally Confused ☐ Confused
Describe any recent changes in mental status _____

COMMUNICATION ABILITY:

	Yes	No	Unknown
Can Speak	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Unknown
Understands Speaking	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language Spoken (other than English) _____			

SOCIAL INFORMATION: Prior to present, Pt. lived:

- | | | |
|--------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Alone | <input type="checkbox"/> Nursing home | <input type="checkbox"/> With friends |
| <input type="checkbox"/> Other | <input type="checkbox"/> With family | <input type="checkbox"/> Assisted Living |

ATTACHMENTS:

- | | |
|---|---|
| <input type="checkbox"/> Lab | <input type="checkbox"/> Surgical Report |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Legal Guardianship |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Durable P.O.A. |
| <input type="checkbox"/> PT Notes | <input type="checkbox"/> Health Care P.O.A. |
| <input type="checkbox"/> H&P (Current) | <input type="checkbox"/> Living will (Terminally ill Declaration) |
| <input type="checkbox"/> Discharge | <input type="checkbox"/> Other _____ |

Sesame Street RN anytime 2023
Signature (Nurse) Title Date

Patient's Name Bert, yellow

NKMA

PRIMARY & SECONDARY DIAGNOSIS: Include surgical procedures & dates

Renal Failure, pulmonary hypertension, CHF, COPD, Gerd

COMFORT measures only, NO code, NO CPR, NO intubation, NO Ventilation, NO Chemical code.

Open areas ☐ Yes ☐ No Describe site & size

Foley Catheter: #1162 Foley size _____ Date last changed _____ Diagnosis for catheter incontinence

☒ Activity as tolerated ☐ Other

Weight Bearing: ☐ Full ☐ Partial ☐ _____ #'s ☐ RT ☐ LT ☐ None

☐ Skilled Nurse _____ /
frequency/order

☐ Physical Therapy _____ /
frequency/order

☐ Occupational Therapy _____ /
frequency/order

☐ Speech Therapy _____ /
frequency/order

☐ Respiratory Therapy _____ /
frequency/order

☐ Home Health Aide _____ /
frequency/order

DIET: As tolerated

☐ CODE ☐ NO CODE☐ Improve ☐ Remain Static ☐ Deteriorate

☒ Acute ☐ Nursing Facility ☐ Assisted Living "I certify that extended care facility (ECF) services are required on an inpatient, continuous basis due to the current medical condition(s) in this document."

~~Patient is unable to get up from bed without assistance,~~
is unable to ambulate, and is unable to ride in a wheelchair.

PATIENT KNOWS DIAGNOSIS: ☐ Yes ☐ No If No, why?

SIGNATURE OF PHYSICIAN: James H. Helt, MD

DATE: *11/17/00*

Patient Care Report
Lincoln Fire & Rescue
City of Lincoln

			Times	Response Analysis
Action Taken 07 MEDICAL	Level 01 BLS	Refusal 01 NOT APPLI	Dispatch Notified 03:26:16	Dispatch 00:02:43
Scene Address	Rm	Location Type	Unit Notified 03:28:59	Chute 00:02:27
12345 E ANYWHERE ST		331 HOSPITAL	Unit Enroute 03:31:26	To Scene 00:13:20
LINCOLN, NE		Response Code to Scene	Arrived Scene 03:42:19	At Scene 00:14:33
		03 NON-EMERGENCY (CODE 1)	Enroute Dest 03:56:52	Transport 00:09:35
			Arrived Dest 04:06:27	At Dest 00:26:53
			Back in Service 04:33:20	Tot Time 01:04:21
				Loaded M1 4.1

Patient # 0001	Name ERNIE, ORANGE	SSN	Gender FEMALE	DOB 01/01/19
Address 0	City LINCOLN	St NE	Zip	Phone
Race 01 CAUCASIAN	Age 84 Yrs 0 Mos	Weight:	Patient Key # 333333	
Dispatched As 66 ROUTINE TRANSFER	Trauma Injury? NO			
Chief Complaint 55 NO COMPLAINT	Glasgow Coma Scale:		Trauma Scale:	
Provider Impression 06 ALZHEIMERS DISE 43 DEPRESSION	Location:		Vehicle Info:	
	Safety Device:		Ejected:	

Patient Medical History	Current Medications	Allergies
DEMENTIA DEPRESSIVE DISORDER CAD PALPATATIONS	LASIX POTASSIUM DARVOCET CELEXA ZANTAC	PCN

Injury/Illness Detail		
Type	Major Area	Minor Area
06 ALZHEIMERS DISEASE	03 HEAD	31 SCALP / BRAIN / CNS
43 DEPRESSION	03 HEAD	31 SCALP / BRAIN / CNS

Vitals									
Severity	Pupils	Chest	Skin Moisture	Skin Color	Abdomen	Temp	APGAR	Burn %	02 Sat
01 MINOR - VIT NOT OBTAINED		06 BOTH RHONCHI	01 NORMAL	01 NORMAL	01 NORMAL				91
Time	Position	Pulse	L.O.C.	Resp	BP	Rhythm			
03:57	02 SITTING	0084	01 CONSCIOUS - ALERT	22	104/P	98 NOT OBTAINED			
04:08	02 SITTING	0090	01 CONSCIOUS - ALERT	24	136/070	98 NOT OBTAINED			

Treatments		Actions/Medications				
Procedure	Unit Id	Time	Action/Medication	Att.	Amt.	Emp Id Effect
52 POSITIONED PATIENT (SHOCK ETC)						

Disposition		
Control Hospital 00 NOT APPLICABLE	Mode of Transport 01 AMBULANCE	
Transported To	Dest Determined By OTHER	
Address	St	Zip

Comments

Patient: Orange Ernie

Dispatched to Hospital B's ER-Omega. Patient was seen at ER for dyspnea and decreasing oxygen sats. ER unable to find any medical causes and also unable to determine dyspnea. SA02=91% since arrival. Patient denied any complaints. Patient now being returned to nursing home for continued care. CAO normal orientation for patient, skin warm and dry, pink. Right eye removed, left eye reactive. L/S rhonchi throughout, no resp distress, SA02=91% ambient air. Abd soft non-tender, MSC intact x 4. Moved to cot to ambulance. Transferred to nursing home without incident. Transferred care and gave staff RN the report. Moved patient to bed.

Physician's Medical Necessity
Certification

PCS

For Non-Emergency Scheduled and
Unscheduled Medical Transportation Services

Unit ID#:

M

Incident #:

Last Name Name: <u>Ernie,</u>		First Name <u>Orange</u>		Middle Initial	Date of Certification:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:		Age:		Patient's SSN:
Medicare No:			Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicaid No:

OPTION 1

- ☐ In my professional medical opinion, this patient requires transport by ambulance and should not be transported by other means. The patient's condition is such that transportation by medically trained personnel is required. The Medicare definition of Bed Confined for non-emergency ambulance transportation is: The inability to get up from bed without assistance and the inability to ambulate and the inability to sit in a chair, including wheelchair.

Does the patients condition meet Medicare's definition of Bed Confined? ☐ YES ☐ NO

If the patient does not meet bed confined criteria as defined above, can this patient be safely transported by wheelchair van? ☐ YES ☐ NO

If NO, please check the appropriate medical conditions listed below which would be necessitate transported by ambulance.

- | | |
|---|--|
| <input type="checkbox"/> Requires continuous oxygen and monitoring by trained staff | <input type="checkbox"/> Has decubitus ulcers & requires precautions |
| <input type="checkbox"/> Required airway monitoring or suctioning | <input type="checkbox"/> Requires isolation precautions |
| <input type="checkbox"/> Requires restraints or sedation | <input type="checkbox"/> Patient requires continuous IV therapy |
| <input type="checkbox"/> Comatose & requires trained monitoring | <input type="checkbox"/> Requires continuous cardiac monitoring |
| <input type="checkbox"/> Had to remain immobile because of a fracture or possibility of a fracture which had not been set | <input type="checkbox"/> Is exhibiting signs of a decreased level of consciousness |
| <input type="checkbox"/> Patient is ventilator dependent and/or requires mechanical ventilation (BVM) | <input type="checkbox"/> Is on hip precautions and cannot sit safely |
| <input type="checkbox"/> Contractures | <input type="checkbox"/> Other (explain) <u>chronic difficulty</u> |
- with O2 synthesizing

OPTION 2

- ☐ In my professional medical opinion, this patient does not require transport by ambulance and can safely be transported by other means.
- ☐ Patient can safely support him/herself while seated in wheelchair and does not require monitoring by trained personnel
- ☐ Patient is able to tolerate transportation by automobile or wheelchair van.

Print the ordering

Physician's Name here.

UPIN:

Physician's signature: Sesame Street, MD

Date: Anytime 2003

I certify that the above information represents an accurate assessment of the patient's medical condition(s). I understand that this information will be used by the Health Care Financing Administration to support the determination of medical necessity for ambulance service.

Doctors

order taken by: _____

Date: ____/____/____

Without a complete form, the patient will not receive Medicare benefits for ambulance transportation.

Please give completed form to the ambulance crew at the time of transport, or fax to Lincoln Fire & Rescue at (402) 441-3832

Patient Care Report
Lincoln Fire & Rescue
City of Lincoln

Action Taken 07 MEDICAL				Level 01 BLS	Refusal 01 NOT APPLI	Times		Response Analysis	
Scene Address				Rm	Location Type	Dispatch Notified 11:13:00		Dispatch 00:01:35	
12345 N ANYWHERE ST					331 HOSPITAL	Unit Notified 11:14:35		Chute 00:00:43	
LINCOLN, NE					Response Code to Scene	Unit Enroute 11:15:18		To Scene 00:17:43	
					03 NON-EMERGENCY (CODE 1)	Arrived Scene 11:32:18		At Scene 00:07:50	
						Enroute Dest 11:40:08		Transport 00:11:56	
						Arrived Dest 11:52:04		At Dest 00:11:45	
						Back in Service 12:03:49		Tot Time 00:49:14	
								Loaded M1 3.5	

Patient # 0001	Name GROVER, BLUE	SSN	Gender FEMALE	DOB 01/01/19
Address 0	City LINCOLN	St NE	Zip	Phone
Race 01 CAUCASIAN	Age 84 Yrs 0 Mos	Weight:	Patient Key # 333333	
Dispatched As 66 ROUTINE TRANSFER		Trauma Injury? NO		
Chief Complaint 55 NO COMPLAINT		Glasgow Coma Scale:		Trauma Scale:
Provider Impression 998 N.O.S. - NOT OT		Location:		Vehicle Info:
		Safety Device:		Ejected:

Patient Medical History	Current Medications	Allergies
SEE HOSPITAL LIST	SEE HOSPITAL LIST	SEE HOSPITAL LIST

Injury/Illness Detail		
Type	Major Area	Minor Area
998 N.O.S. - NOT OTHERWISE SPECIFIED	01 GENERAL	10 GENERAL

Vitals									
Severity	Pupils	Chest	Skin Moisture	Skin Color	Abdomen	Temp	APGAR	Burn %	02 Sat
01 MINOR - VIT P.E.A.R.L.		01 BOTH CLEAR	01 NORMAL	01 NORMAL	01 NORMAL				99

Time	Position	Pulse	L.O.C.	Resp	BP	Rhythm
11:53	03 LYING	0080	01 CONSCIOUS - ALERT	16	120/060	98 NOT OBTAINED
12:02	03 LYING	0080	01 CONSCIOUS - ALERT	16	120/P	98 NOT OBTAINED

Treatments		Actions/Medications				
Procedure	Unit Id	Time	Action/Medication	Att.	Amt.	Emp Id Effect
98 OTHER (EXPLAIN IN COMMENTS)						

Disposition		Mode of Transport	
Control Hospital 00 NOT APPLICABLE		01 AMBULANCE	
Transported To		Dest Determined By OTHER	
Address	St	Zip	

Comments

Patient: Blue Grover

Dispatched to an Omega call. A pick up in the ER at hospital B and transport to nursing home. Found the patient lying supine in a hospital bed, alert/oriented x 4, warm, pale and dry. The patient had no chief complaint. Patient had been evaluated in the ER because staff had difficulty awaking her this AM. The patient's evaluation in the ER was normal. The patient had no chief complaint after a brief assessment. The patient's paperwork was gathered and the patient was moved to the cot and to the ambulance. The patient was transported to nursing home without incident. The patient was made comfortable enroute with no changes in condition. On arrival at nursing home, the patient was moved to the bed with the assistance of the staff. Patient care was transferred to nursing home staff.

Physician's Medical Necessity Certification

PCS

For Non-Emergency Scheduled and
Unscheduled Medical Transportation Services

Unit ID#:

M

Incident #:

Last Name Name: <u>GROVER,</u>		First Name <u>Blue</u>	Middle Initial	Date of Certification:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:	Age:		Patient's SSN:
Medicare No:		Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicaid No:

OPTION 1

☒ In my professional medical opinion, this patient requires transport by ambulance and should not be transported by other means. The patient's condition is such that transportation by medically trained personnel is required. The Medicare definition of Bed Confined for non-emergency ambulance transportation is: The inability to get up from bed without assistance and the inability to ambulate and the inability to sit in a chair, including wheelchair.

Does the patient's condition meet Medicare's definition of Bed Confined? ☐ YES ☒ NO

If the patient does not meet bed confined criteria as defined above, can this patient be safely transported by wheelchair van? ☒ YES ☐ NO

If NO, please check the appropriate medical conditions listed below which would necessitate transport by ambulance.

- ☐ Requires continuous oxygen and monitoring by trained staff
- ☐ Required airway monitoring or suctioning
- ☐ Requires restraints or sedation
- ☐ Comatose & requires trained monitoring
- ☐ Had to remain immobile because of a fracture or possibility of a fracture which had not been set
- ☐ Patient is ventilator dependent and/or requires mechanical ventilation (BVM)
- ☐ Contractures

- ☐ Has decubitus ulcers & requires precautions
- ☐ Requires isolation precautions
- ☐ Patient requires continuous IV therapy
- ☐ Requires continuous cardiac monitoring
- ☐ Is exhibiting signs of a decreased level of consciousness
- ☐ Is on hip precautions and cannot sit safely
- ☐ Other (explain) _____

OPTION 2

- ☐ In my professional medical opinion, this patient does not require transport by ambulance and can safely be transported by other means.
 - ☐ Patient can safely support him/herself while seated in wheelchair and does not require monitoring by trained personnel
 - ☐ Patient is able to tolerate transportation by automobile or wheelchair van.

Print the ordering

Physician's Name here.

UPIN:

Physician's signature: Sesame Street, MD

Date: Anytime, 2003

I certify that the above information represents an accurate assessment of the patient's medical condition(s). I understand that this information will be used by the Health Care Financing Administration to support the determination of medical necessity for ambulance service.

Doctors

order taken by: _____

Date: ____/____/____

Without a complete form, the patient will not receive Medicare benefits for ambulance transportation.

Please give completed form to the ambulance crew at the time of transport, or fax to Lincoln Fire & Rescue at (402) 441-3832

Patient Care Report
Lincoln Fire & Rescue
City of Lincoln

				Times	Response Analysis
Action Taken 07 MEDICAL	Level 01 BLS	Refusal 01 NOT APPLI	Dispatch Notified 06:53:05	Dispatch 00:00:32	
Scene Address	Rm	Location Type	Unit Notified 06:53:37	Chute 00:00:56	
12345 S ANYWHERE ST		312 RETIREMENT HOME, NO NUR	Unit Enroute 06:54:33	To Scene 00:02:06	
LINCOLN, NE		Response Code to Scene	Arrived Scene 06:55:43	At Scene 00:16:48	
		03 NON-EMERGENCY (CODE 1)	Enroute Dest 07:12:31	Transport 00:08:05	
			Arrived Dest 07:20:36	At Dest 00:00	
			Back in Service 00:00:00	Tot Time 00:00	
				Loaded Ml 3.5	

Patient # 0001	Name GROUCH, OSCAR T	SSN	Gender FEMALE	DOB 01/01/19
Address 0	City LINCOLN	St NE	Zip	Phone
Race 01 CAUCASIAN	Age 84 Yrs 0 Mos	Weight:	Patient Key # 333333	
Dispatched As 36 OVERDOSE/DRUGS/ALCOHO	Trauma Injury? YES	17 FALL < 15 FEET		
Chief Complaint 39 PSYCHIATRIC EMERGENCY	Glasgow Coma Scale: 0015 0015	Trauma Scale: 0012		
Provider Impression 84 MENTAL DISTURBA 88 OVERDOSE	Location:	Vehicle Info:		
	Safety Device:	Ejected:		

Patient Medical History	Current Medications	Allergies
OBESITY DEPRESSION/ANXIETY EPILEPSY	MED LIST GIVEN TO ER RN	NKDA

Injury/Illness Detail		
Type	Major Area	Minor Area
84 MENTAL DISTURBANCE	03 HEAD	31 SCALP / BRAIN / CNS
88 OVERDOSE	02 ILLNESS/DISEASE/SYSTEMIC DISORDER	20 ILLNESS/DISEASE/SYSTEMIC DISORDER

Vitals									
Severity	Pupils	Chest	Skin Moisture	Skin Color	Abdomen	Temp	APGAR	Burn %	02 Sat
01 MINOR - VIT NOT OBTAINED		01 BOTH CLEAR	01 NORMAL	01 NORMAL	01 NORMAL				100

Time	Position	Pulse	L.O.C.	Resp	BP	Rhythm
07:00	02 SITTING	0088	01 CONSCIOUS - ALERT	20	120/072	01 NORMAL SINUS RHYTHM
07:10	02 SITTING	0088	01 CONSCIOUS - ALERT	20	160/100	98 NOT OBTAINED

Treatments		Actions/Medications				
Procedure	Unit Id	Time	Action/Medication	Att.	Amt.	Emp Id Effect
54 CARDIAC MONITOR						
50 PSYCHOLOGICAL ASSISTANCE						

Disposition					
Control Hospital 00 NOT APPLICABLE	Mode of Transport 01 AMBULANCE				
Transported To	Dest Determined By DIVERSION				
Address	LINCOLN	St	Zip		
Comments					

Patient: Oscar T. Grouch

Medic unit and engine unit arrived at the same time. Response code was bravo for a patient that had fallen at the retirement home.

HPI: Patient was attempting to get out of bed this am and the next thing she knew was that she was on her hands and knees on the carpeted floor of her room. The staff found her next to the bed and stated that the patient was unusually disoriented. The patient stated that she did not have any pain but that she could not remember how she fell.

Assessment: patient AAOX3. Shows no signs of physical trauma. Patient has no complaint of pain. Speech clear. No sign of CVA/TIA. Staff stated that the patient appeared to be post ictal initially. The patient is obviously emotionally distraught and cries frequently. The patient stated that her husband passed away 5 years ago but that dealing with his death for the past year has been very hard. Patient stated that she took the diet pills over the past 3 days and took more than the recommended dose because she wanted to lose weight. Patient denies having any thoughts to hurt herself in any way.

Neck: No pain on palpitation. No deformities. Chest: Clear and = bilat. No pain, no dyspnea. ABD: No N/V. Stated that she ate last night and that her urination and B.M. were normal. Patient has no pain in her extremities. Patient has no distal deficits noted. Patient usually walks with the assistance of a cane.

Treatment: No emergency treatment required. Emotional support was given.

Transported to Hospital A ER with no changes in stable medical condition. Patient report, paperwork and care transferred to ER RN.

Impression: Depression. 3 day OD of diet pill Phentermine. The 27 pills were dispensed 3 days ago and presently there are only 3 pills left this AM. Patient stated that she couldn't remember when she took the pills last.